myers | stevens | toohey

Student Accident & Sickness Insurance
CLAIM FILING INSTRUCTIONS

FOR PARENTS/LEGAL GUARDIANS (or students of legal age)

Coverage terms and conditions

Prior to an injury or sickness occurring or as soon as possible thereafter, please familiarize yourself with the terms and conditions of coverage including: what activities are covered; benefits; exclusions; requirements and limitations; important deadlines, etc. These may be found in policies on file with school/parish authorities, printed brochures used to secure coverage, online or by contacting us directly at (800) 827-4695.

Claim form and reporting

Report school/parish related injuries immediately to a staff person, providing as much detail as possible.

Request a Student Accident & Sickness Insurance claim form from the school/parish and ask an authorized official to COMPLETELY AND LEGIBLY fill out Part A of the form. If the reported injury is not school/parish-related, you may fill out Part A yourself. Only one claim form is required per injury or condition.

COMPLETELY AND LEGIBLY fill out Part B (missing fields will cause delays) provide signatures where requested, date and return to our office along with your itemized bills and Explanations of Benefits (EOBs) from any other applicable insurance or health plan.

Finding a health provider

You are free to take your child to any properly licensed health provider but out-of-pocket costs may be reduced if you seek care from providers who are contracted under the *First Health Network* or *First Choice Health Network* (WA only). Contracted providers may be found at www.firsthealth.com (800) 226-5116 or www.fchn.com (800) 231-6935. If your child also has coverage through an HMO, please know that benefits under many of our school/parish-paid blanket plans may be reduced if you seek out-of-network services that are not preauthorized by your HMO. This potential benefit limitation does not apply to any of our individually purchased plans and does not apply to emergency care.

When treatment is sought

Give the provider's billing/admissions person your primary insurance/health plan information (if applicable).

If you purchased one of our individual plans for your child, present your student insurance ID Card. If your child is covered under a blanket plan that is paid for by the school/parish, let the billing person know that and identify the district, Diocese or other school system involved and the specific school/parish. In either case, explain that your child has medical expense insurance that provides benefits on an excess or secondary basis and that it is NOT what is sometimes referred to as "third party" insurance. Your child is the insured.
Ask the billing person to add Myers-Stevens & Toohey into their system as a payor and to either send us the itemized bills described above directly (preferred!) or to send you those same bills to be forwarded to us. Letting the provider know that you are assigning benefits to them may help smooth the process. If you have difficulty, please contact us and we'll be happy to help.

If your child has other insurance or health coverage

File a claim with that primary plan (except Medicaid) and send us copies of their "Explanation of Benefits" or "EOBs" once processed.

What we need from the providers who see your child*

In order to evaluate your claim and provide benefits, we will need fully itemized bills from any providers seen. These are known as HCFA 1500 or CMS 1500 forms from providers such as doctors and as a UB04 form from facilities such as hospitals and surgery centers. They contain the following required information:

- Date(s) of Service
- Billed Charges
- Diagnostic Codes - these tell us what is wrong with your child
- Procedural or Revenue Codes - these tell us what was done to evaluate/treat the problem
- Provider Tax ID Number - needed to issue W-9s when benefits are assigned to providers
- National Provider Identifier (NPI) - needed to comply with Federal regulations

NOTE – we are not able to use "statements" from providers, primary health plan EOBs or a receipt of payment in lieu of the required itemized billings as described above.

**If you have Kaiser, request "courtesy statements" from Kaiser Member Services that include the information listed above. Please make sure the documentation submitted indicates what portion of the charges, if any, you are obligated to pay out of your own pocket.*

Final Steps

Send: 1) Completed claim form; 2) Itemized bills; 3) Other insurance/health plan EOBs (when applicable) to:

MYERS-STEVENS & TOOHEY
Attn: Claims Department
26101 Marguerite Parkway
Mission Viejo, CA. 92692

OR **Fax: (949) 348-9350** *OR* **Email: claimsinfo@myers-stevens.com**

Need more help? Call us at (800) 827-4695

myers | stevens | toohey

STUDENT ACCIDENT & SICKNESS INSURANCE CLAIM FORM

Email: reportclaims@fnsb.gov & risk-manager@k12northstar.org

PART A SCHOOL/PARISH STATEMENT

(Parent or legal guardian may complete Part A if injury is not school/parish-related)

NAME OF CLAIMANT FIRST MI LAST | AGE | ☐ FEMALE ☐ MALE | DATE OF BIRTH MO / DAY / YR

ADDRESS OF CLAIMANT CITY STATE ZIP CODE

IS THE CLAIMANT A: ☐ STUDENT ☐ STAFF ☐ VOLUNTEER ☐ OTHER _____ | ID # FROM ID CARD (If applicable)

NAME OF SCHOOL/PARISH | NAME OF DISTRICT, DIOCESE OR OTHER SCHOOL SYSTEM

SCHOOL/PARISH MAILING ADDRESS CITY STATE ZIP CODE

DURING WHAT ACTIVITY DID THE INJURY OCCUR? ☐ INTERSCHOLASTIC PRACTICE ☐ INTERSCHOLASTIC GAME ☐ P.E. ☐ CLASSROOM ☐ PLAYGROUND ☐ TRAVEL ☐ AT HOME ☐ FIELD TRIP ☐ RELIGIOUS EDUCATION ☐ CONFIRMATION ☐ YOUTH MINISTRY ☐ YOUNG ADULT MINISTRY ☐ CYO ☐ PAL ☐ OTHER _____

WAS THE CLAIMANT PARTICIPATING IN A SPORT NOT SCHOOL/PARISH-SPONSORED AND SUPERVISED? ☐ YES ☐ NO
IF YES, LIST NAME OF SPORTS ORGANIZATION: | TYPE OF SPORT: | DOES THE SCHOOL/PARISH HAVE ANY RECORD OF ANY HEALTH COVERAGE FOR THE CLAIMANT? ☐ YES ☐ NO
If YES, name of plan:

DATE OF INJURY/SICKNESS MO / DAY / YR | TIME OF INJURY : A.M. / P.M. (CIRCLE ONE) | WHAT **PART** OF THE BODY WAS INJURED? ☐ LEFT ☐ RIGHT | HAS THE CLAIMANT SUFFERED FROM SAME OR SIMILAR CONDITION BEFORE? ☐ YES ☐ NO IF YES, WHEN?

PROVIDE DETAILS ON HOW AND WHERE THE INJURY OR ILLNESS OCCURRED. PLEASE BE SPECIFIC

NAME AND TITLE OF SUPERVISING OFFICIAL AT TIME OF INJURY | WAS HE/SHE A WITNESS TO THE ACCIDENT? ☐ YES ☐ NO | DATE SCHOOL/PARISH WAS NOTIFIED / /

NAME AND TITLE OF OFFICIAL COMPLETING FORM | SIGNATURE X | DATE SIGNED | SCHOOL/PARISH TELEPHONE NUMBER ( )

PART B PARENT OR LEGAL GUARDIAN INFORMATION

NAME OF CLAIMANT'S PRIMARY PHYSICIAN | ADDRESS | PHONE NUMBER ( )

IS THE CLAIMANT COVERED, DIRECTLY AND/OR AS A DEPENDENT UNDER ANY OTHER INSURANCE OR HEALTH PLAN(S)? ☐ YES ☐ NO
IF YES, NAME OF PLAN(S) | POLICY NUMBER(S)

NAME OF CLAIMANT'S EMPLOYER (if applicable) | ADDRESS | PHONE NUMBER ( )

NAME OF FATHER OR LEGAL MALE GUARDIAN | MOBILE TELEPHONE NO. ( ) | HOME TELEPHONE NO. ( )

ADDRESS CITY STATE ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed | WORK TELEPHONE ( )

ADDRESS OF EMPLOYER CITY STATE ZIP CODE

NAME OF MOTHER OR LEGAL FEMALE GUARDIAN | MOBILE TELEPHONE NO. ( ) | HOME TELEPHONE NO. ( )

ADDRESS CITY STATE ZIP CODE

NAME OF EMPLOYER ☐ Self Employed ☐ Part Time ☐ Unemployed | WORK TELEPHONE ( )

ADDRESS OF EMPLOYER CITY STATE ZIP CODE

AUTHORIZATION: I hereby authorize any School, Participating Organization, Policyholder, trust, employer, insurance company, health plan, medical/dental provider or other person or entity to release any information/documentation needed to process this claim to Myers-Stevens & Toohey & Co., Inc. (MST) or its insuring company when requested by them to do so. This may include but is not limited to: details of the reported loss; identification of witnesses and supervisors; verification of other insurance or health coverage; coverage terms; explanations of benefits; complete health records including those involving mental/emotional disorders and substance abuse; prescription drug history and fully itemized bills in the form of CMS/HCFA 1500s and UB04s. If the claim is reportedly the result of participating in a School, Participating Organization or Policyholder activity, I authorize MST to share information concerning this claim as necessary with representatives of the School, Participating Organization or Policyholder as applicable. I understand that the authorization to release claim-related information/documentation to MST will terminate two years from the date of signature unless terminated in writing on an earlier date by me. A photo static/digital copy of this authorization shall be considered as valid and effective as the original.

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE X _____ DATE _____

ASSIGNMENT OF BENEFITS: I authorize the payment of benefits directly to the provider(s) of services and/or supplies associated with this claim.

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE X _____ DATE _____

FRAUD WARNING: Any person who knowingly and with intent to defraud any insurance company or other persons, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, subject to criminal prosecution and/or civil penalties.
I have read and acknowledge the General Fraud Warning above and the specific version for my state on the reverse side.

NAME _____ RELATIONSHIP TO CLAIMANT _____ SIGNATURE X _____ DATE _____